A SURVEY OF THE CALGARY GENERAL HOSPITAL AND THE CALGARY ISOLATION HOSPITAL - June 1936

by Harvey Agnew, M.D., Secretary, Department of Hospital Service, Canadian Medical Association.

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Introduction

The Calgary Hospitals Board, at a meeting on April 7th,1936, passed a resolution appointing a committee of three "to consider ways and means of obtaining competent professional advice re improving hospital and reducing costs and the probable cost of advice, and to report back." After due consideration it was authorized by the Board that the survey be made by the undersigned.

In accepting this request, it was understood and was confirmed by the Chairman of the Board that this survey should be a general one, covering both the Calgary General Hospital and the Isolation Hospital, that it should include a review of the physical plant, the method of administration, the professional services, including nursing, and should especially focus attention upon the possibilities of effecting economies in operation. In accordance with this brief, the Report, based upon a survey made June 11th - 14th 1936, is being presented under the various headings which immediately follow.

It is understood that this survey is being requested by the Hospital Board, not because of any widespread dissatisfaction with the efficiency of the Management nor with the expectancy of finding negligence on the part of anyone, but rather with the desire to leave no stone unturned in gaining the fullest possible efficiency of service which would be compatible with a limited budget.

It soon became apparent in this study that, owing to the present financial stringency, there would be a tremendous gap between what is obviously needed, particularly with respect to the physical plant, and what is feasible under current economic conditions. Accordingly, in the recommendations made, particularly with respect to plant, the ideal arrangement is set forth creating, as it were, a goal toward which to aim, but modified recommendations, less Utopian but more immediately practicable, are included where possible.

The writer desires to express his appreciation of the wholehearted co-operation of everyone interviewed in making this survey. Quite a few of the personnel voluntarily gave up their days off to be available for interrogation or to demonstrate their particular departments. Books and records were entirely at his disposal. Naturally this full co-operation greatly facilitated the study.

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11. HISTORICAL REVIEW AND MANAGEMENT

The Calgary General Hospital was incorporated in 1890 and the first building was built in 1896, being sponsored by a public spirited group of leading citizens.

In 1910 the site was changed and the present building was erected. This was financed partly by public subscription and partly by a municipal contribution. The hospital, however, remained under a private voluntary board. During this period the financial problem of maintaining the institution and of caring for the poor was steadily increasing. At a meeting of subscribers on January 27th,1913, it was agreed that the City should be asked to pay $1.25 per diem for its non-pay resident patients; as an alternative the City would be asked to care for and provide accommodation for the sick poor of Calgary. Finally in 1918 the City accepted the property of the Calgary General Hospital and assumed its management.

The Hospital Board - For some years it was operated directly under the City Council. However, there was a strong movement, sponsored by Alderman W. A. Lincoln, for the appointment of a Hospital Board and, in 1933, following a plebiscite, the Calgary Hospital Board was created under the Chairmanship of Mr. S. H. Adams, K.C. This Board is composed of nine members:

The Mayor of the City of Calgary (ex officio)
Two members of the City Council
Six citizens chosen by the City Council

The latter six are not to be members of the City Council and are appointed for two years, three being appointed each year.

In the Calgary Hospital Board "shall be vested the general management, regulation and control of the Municipal Hospitals of the City of Calgary" - (Bylaw 308-1). The City Treasurer is Treasurer of the Board, - (Bylaw 308-21). Moreover, "notwithstanding any incorporation of the Calgary Hospitals Board, the City shall be and remain liable in connection with the operation of the said Hospitals to the same extent and effect as if the said Hospitals Board had not been incorporated" - (Bylaw 308-2a). The Board submits its estimates, etc. to the City Council which reserves the right to alter, modify or refer back such proposed estimates - (308-20a).

Among the powers and duties of the Hospital Board are the rights to (a) fix fees chargeable; (b) appoint, dismiss, and suspend officers, servants and nurses of the Hospitals and to fix wages and salaries; (c) to prescribe the hospital duties of the Medical Health Officer, Superintendent, Business Manager or any other official or employee of the City Hospitals; (d) to make agreements with individuals or groups for the supply of hospital benefits; (e) to contract for supplies; (f) to make general regulations for the administration of the Hospitals subject to certain defined restrictions - (bylaw 308-22). (See comments under Management and Administration).

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111. ANALYSIS AND RECOMMENDATIONS[x]

(x Recommendations are not summarized in one chapter, for in a comprehensive study of this nature, it would seem best that the recommendations should appear in association with the relevant text.)

A. PHYSICAL PLANT

The Calgary General Hospital has an official capacity of 191 beds and 24 bassinets. It provides surgical, medical and obstetrical facilities; has a small children's ward and has radiological and pathological departments. All patient accommodation is in one building.

Overcrowding - It is very obvious that the building is badly overcrowded. The average census for the past year has been 200 patients. During the Survey, enquiry revealed that the census that day was 202; the census has been as high as 223 recently. This places an impossible task upon the administration, for it is well recognized that when the census rises above 80 per cent of the official capacity it becomes exceedingly difficult to properly segregate and care for patients suffering from various types of diseases. This difficulty is much enhanced when the accommodation is of the flexible nature provided here. Patients often require moving several times before being finally located. So difficult is it to provide space for patients that extra beds have had to be set up in large wards and elsewhere and many of the two-bed wards are obviously big enough for but one bed. One would strongly suspect that in some instances these set-ups contravene the regulations requiring a specified floor area and cubic footage, especially where the ventilation is through a window opening not to the outside atmosphere but to a glassed-in porch.

The recommendation of the Standardization Committee is strongly supported:

> "--that chronic cases requiring institutional care such as incurables, cripples, senile cases, tuberculosis patients awaiting transfer to Sanatorium, etc., should not be retained in the hospital thereby occupying beds, but should be cared for elsewhere, thus providing a larger number of beds for cases requiring hospital attention."

It is realized, of course that, at present, such other accommodation is sadly lacking.

The Medical Staff particularly regrets the detention of insane patients pending transfer to Ponoka. This is most unsatisfactory, uses up needed space and is a heavy strain on the nursing and orderly staffs.

Whether or not Mountview Home with its 50 beds could be utilized for chronic patients, incurables, etc., would be worthy of further study. In the absence of other facilities, such arrangement would appear desirable.

LAYOUT:

The general layout is obsolete and unsatisfactory in many respects. For example:

General Wards -- These are too large, making segregation extremely difficult. Few wards are now built holding more than six or eight to a section.

LAYOUT: (cont'd)

Kitchen - The kitchen is on the top floor, a plan conceived to prevent ascending food odours from permeating the hospital, but the idea has been long since abandoned because it adds tremendously to the transportation problems, to traffic congestion and is wasteful of effort and time.

Dining Rooms - The pupil nurses have a cafeteria system which would seem to be operating satisfactorily. The other dining rooms open off the kitchen on the top floor, are crowded and are permeated with odours of cooking. This cannot be changed to any extent now, although if the walls between the kitchen and the corridor were filled in, leaving serving windows and doors only, the noise and odours could be reduced somewhat. A private dining room should be available for the senior members of the administration staff.

Dressing Room Facilities - These are inadequate and not strategically placed.

Paediatric Ward - With eight or nine cots in one room and four in another, adequate segregation of children is impossible. The washroom is very dark. Ventilation is bad. A new paediatric department is urgently needed.

Elevators - But one elevator is provided for the entire building. This must handle all traffic of doctors, nurses and visitors, all movement of patients to and from the X-ray department, etc., all transportation of food and supplies to the kitchen above, some of the meals, although fortunately not all, garbage, linen, removal of bodies, and freight in general. One more elevator should be installed to provide a service elevator. As space inside is at a premium, an outside shaft may be required. The use of a direct current generator and an A.C. motor as at present installed adds greatly to the noise in the hospital.

Office Facilities - The office space is quite inadequate for the work required. The business manager's office is so filled with files that there is barely room beside the desk for visitors. The Medical Superintendent has no office at all other than Mr. Barnes' room. The assistant superintendent of nurses and the instructress have a small office made by closing in a balcony.

The public and general offices are exceedingly cramped, the resultant interference and inability to properly spread out or leave work causing added delay.

Ventilation - None other than natural ventilation is available, the built-in system having broken down years ago. In cold weather adequate ventilation is a real problem. Rooms opening onto closed-in balconies are particularly hard to ventilate.

Morgue - The morgue is outside the main building. The procedure required to evacuate bodies is very time-consuming. As the orderly must first go to the morgue to get the tray, two outside trips must be made. The porter must be found to assist in the procedure. The head orderly states that the removal of a body to the morgue can seldom be accomplished in less than twenty minutes.

Waiting Room - This is a tiny room about 12' x 12' situated some little distance from the entrance. In any expansion of facilities better accommodation should be provided.

Diet Kitchens - These are only about a third of the size which should be provided. On some floors the food racks with food on the trays were noticed standing in the corridors a considerable time before the next meal. This is poor technique and the only excuse is the above lack of space.

LAYOUT: (cont'd)

Obstetrical Department - This is in the east end of the basement floor. There are two case rooms but no labour room, eighteen of the twenty-four patients being required to go through the first stage of labour in semi-private rooms, unless one of the case rooms happens to be empty.

There is a large nursery but no observation nor isolation nursery. There is no room available for the making of dressings, this being done in the corridor. There is a sterilizing room, but the autoclave for pressure sterilization of supplies is elsewhere.

Nursing Facilities - The work of the nurses is considerable augmented by the lack of:

(a) Toilet facilities. There is not a bedpan sterilizer in the hospital, equipment now found in practically all but the small hospitals.

(b) Washbasins - not a room in the hospital contains a washbasin. It is generally agreed now that the provision of this feature more than pays for the cost in the time and effort saved by the nurses.

(c) Signal system - The primitive partial system now in use is not effective and requires two trips to be made for the great majority of requests. This should be replaced by an adequate silent signal flash system. Much of the present delay in finding an orderly could be overcome by a better signal method.

(d) Wardrobes - There are very few wardrobes and the present accommodation for patients' clothing is very inadequate. Until such time as a new building can be built, more wardrobes should be provided.

(e) Nurses' Stations - These important units were not provided for on the various floors, making it necessary that the charting desks and medicine cabinets clutter up the corridors. (It was noted that the key to one of the poison cabinets on the open corridor was left in the door which was open and unguarded.)

X-ray Department:

This is under the direction of Dr. W. S. Quint, who is assisted by Miss Donald. Dr. Quint is employed on a part-time basis, two hours a day and on call at other times. Miss Donald, who does the technical work, the office records, the indexing and the clinical work, is on a five-day week, plus emergency calls. The equipment is obsolete, with the exception of the portable machine, the viewing box and one new tube. The suite needs enlargement and re-designing, particularly with reference to the dressing rooms, the dark room and the consulting room. There is very little x-ray therapy work done. The cross-index files are getting behind, apparently due in part to the multiplicity of duties and the five-day week.

Physiotherapy comes under this department. There is an old fashioned diathermy machine and a more modern quartz lamp which, however, is seldom used. Other equipment, including the now much used inductotherm, is lacking.

These departments are not well patronized. The number of patients treated in 1935 was but 1,834. As an unusually high percentage of these patients were non-pay, the revenue was comparatively small. This situation may be explained in part by the presence in the City of four private radiological laboratories, and another hospital service, and also the distance of the hospital from the doctors' offices and from the homes of the potential paying clientele.

LAYOUT: (cont'd)

Unless the obsolete equipment be replaced and augmented by more modern apparatus, one cannot see how additional patronage can be anticipated.

Whether or not the expenditure of six or eight thousand dollars would so increase the revenue that the capital cost would be returned would require a very intimate knowledge of the local situation. The relative scarcity of private patients in the hospital and the competition of other radiological facilities closer in might offset to some extent the attraction of the new equipment and the confidence felt by the medical profession in the work of the radiologist.

The Pathological Laboratory -

This department is under the direction of Dr. Lola McLatchie, who has for assistants, two full-time technicians and one call technician working part day, part night. Dr. McLatchie is on a part-time basis; calculating her hours at the hospital, her post-mortem work and her time occupied elsewhere on General Hospital work, she estimates that her duties arising from her General Hospital position require a daily average of at least six hours.

In addition to doing the pathological work for the hospital, the laboratory does the routine city work as well - isolation hospital work, sputum, swabs, gonorrhoea smears, etc. Most of the culture media used is made by the staff.

Apparently the present staff can do the usual routine work, but there is no time nor help available for scientific investigations or to build up a pathological collection, complete pathological records, etc. The pathologist reports a need for a technician for tissue diagnostic work. It is difficult to get results when the tissue technician is being constantly called away to do other work. There is need also of a small room near the operating room for rapid section work. While these requests are worthy of strong support, it would seem difficult with the present shortage of both money and space to provide these extra services.

Nurses' Home -

The nurses are housed in three buildings - Block "A" accommodating 68 nurses, Block "B" 29 nurses, Block "C" 8 graduate nurses and the remainder on the Third Floor East of the Hospital. The Superintendent of Nurses has rooms in the Hospital. Twenty of the rooms are double rooms, and there are two dormitories accommodating six and ten nurses respectively. Dormitories should not be tolerated for young women working and studying under such continued pressure as do pupil nurses. There is also very little recreational space or provision, certain of the sitting rooms being occupied as bedrooms for at least six months of the year. Moreover there is no tunnel connection with the hospital for bad weather. There is practically notrunk space in the homes.

Teaching equipment while not elaborate would seem to be reasonably adequate. The nursing service and the training school are discussed later in this Report. (Nursing Service)

The use of a wing of the Hospital proper to house nurses is both wasteful of potential space for patients and is not considered desirable for the nurses, who should, in their off-duty hours, be away from the hospital environment. The erection of a modern unified nurses' residence would seem to be an early consideration.

LAYOUT: (cont'd)

The Heating Plant:

The heating plant has three gas fired boilers. These are 109, 89 and 45 H.P. boilers. Ordinarily the two larger boilers are adequate for winter use but frequently on a cold morning 300 H.P. are needed. This means forcing the boilers considerably beyond their rating and consequently the plant has no reserve power on hand in case of a breakdown. This would be of serious consequence were the breakdown to occur during a cold spell.

The engineer, Mr. Middleton, and Mr. Barnes, have developed various means of getting maximum efficiency from the plant. They are using exhaust steam to warm the hot water with a considerable saving. Stack heat is being utilzed to warm the intake water. The engineer is getting .78 pounds evaporation per cubic foot of gas with an average boiler efficiency of 73.74 per cent. These would seem to be excellent results in view of the opinion from the Canadian Western Natural Gas, Light, Heat and Power Co. Ltd., that the Gwynn Burners used are of obsolete design.

The report of Messrs. W. H. Broughton, R.P.E., A.M.E.I.C. and W.T. Hobson, dated November 10th,1934, was noted. The report of the House Committee, November 12th,1934, accepting this and other reports and commending Mr. Middleton's operation of the boiler plant, despite certain adverse criticism, was also noted. Mr. Middleton's own report of October 30th,1934, gives considerable interesting information about the heating plant.

Repairs have been heavy due to the old equipment. The pipe tunnels, which were inspected, were cramped, unbearably hot and tortuous. These factors naturally add considerably to the time required to make repairs. Wiring is obsolete, also, making it difficult to maintain amperage for the portable x-ray machine.

The change from coal to gas fuel proved a definite economy, as indicated by these figures.

1923 - coal	-	$ 17,000.
1926 - gas	-	12,444.
1935 -gas	-	7,865.

Whether or not the suggested change to a low pressure plant would prove advisable, is a matter for recommendation by engineering experts. Apparently such change would reduce the staff by two, but to offset this there would be considerable new equipment required. (See also under Personnel)

RECOMMENDATIONS RESPECTING PLANT AND REQUIPMENT:

Recommendations with respect to plant and equipment (as considered apart from the matter of personnel and organization discussed in a later section) are not easy to crystallize in view of the financial situation which, in the final analysis, determines whether a suggestion is feasible or not.

New Building - Considered apart from this factor, the hospital is so obsolete that no remodelling or extension can be considered as anything but a temporary and only partially satisfactory palliative. In the light of modern knowledge of hospital administration the hospital was so badly designed that the only real solution is the erection of an entirely new plant, converting the present buildings into a home for incurables, for chronic invalids or, to some extent, for convalescents. The removal of nurses from the east wing would release approximately 25 beds, but this would be of minor value. The number would be less if one, rather than two, patients were housed in a room. The rooms would be too crowded if used for semi-private beds. More space could be obtained by removing the kitchens

LAYOUT: (cont'd)

from the top floor to a special service wing, but the logical place for such would be the present location of the boiler plant. To move this would be too costly. An alternative possibility would be to place the kitchens above the boiler room, incorporating into the remodelling added elevator service, dumb-waiter equipment and enlarged diet kitchens and utility services. To express an opinion upon the feasibility of such a procedure would require an extensive study of the present plans and specifications by expert architects and engineers, Such study is not embraced in this enquiry. Again, however, the extensive cost of such alterations and the partial solution only thus obtainable make one dubious of the advisability of such procedure. The legality of extending hospital facilities over high pressure steam equipment would require early investigation.

Were a new building to be erected, a unit of 300 bed capacity at least should be agreed upon. The present average census is about 200, but this is governed mainly by the fact that the hospital cannot accept any more. The present private rooms are few and not particularly desirable as a whole. Were the new hospital to contain an up-to-date well furnished private section, patronage would be greatly increased. As new hospitals always receive added public and professional support, one could safely predict that even 300 beds would soon be found inadequate during peak periods.

The cost of such a building would depend upon the material used, current costs of such and of labour, and upon the services and equipment provided. Speaking generally, however, an up-to-date hospital with good, although not lavish, equipment can be built for not less than $3,000. per bed.

(Note - The usual round figure given is about $4,000. per bed, but this can be reduced at present prices by omitting various desirable but not essential details.)

This would represent a basic cost of at least $900,000.00 and if one allows for a new nurses' home, equipment and furnishings, possible cost of new site and the inevitable extras which would probably be fairly large at the close per-bed figure given, the total cost might readily be $1,250,000.00.

Site: Any discussion of a new building raises the problem of the site. The present location is very much to one side of the City and while it is comparatively close to the large section of the population in the northerly and easterly portions of the City, it is comparatively inaccessible to the large residential sections of the south and west. As the greater proportion of those unable to pay live in the neighborhood of the Hospital, it is logical that the Hospital would be able to attract a larger proportion of private patients and would receive more radiological patronage, for instance, if the Hospital were not so far to the north-east. It might still serve its present area and be more accessible to the residents in the south-western part of the City were a more strategic location chosen closer in.

The issue before the Hospital Board and the Council would seem to be simply one of whether or not the people are to have a modern up-to-date hospital equipped to provide the most efficient type of service or whether the General Hospital is to be allowed to get still further down at the heel until efficient work be quite impossible. Working under most unusual handicaps, the personnel do seem to be providing a service which is conscientious and which is as efficient as facilities will permit, but with each passing year these handicaps are going to become greater, not only in fact but in comparison with other more progressive institutions. In the face of the present financial stringency one cannot urge what is most obvious to any trained observer, the building of a complete new 300 bed hospital, but it should be realized by all responsible citizens that sooner or later this issue must be faced and that, while temporary changes may

LAYOUT: (cont'd)

help the situation, such cannot long delay the construction of a new building. While the immediate objective of this survey was to find possible ways for further economy, the obsolete nature of the plant and equipment soon became evident as major factors in any study of costs.

If the times be not propitious for the erection of a new building, the decision will have to be made whether to remodel the present building to provide better accommodation and more adequate facilities, or to remain in status quo. The latter policy may be more in keeping with the present and, in many instances, necessitous policy of retrenchment, but, in view of the excellent hospital facilities available elsewhere in Calgary, such policy cannot but result in definitely diminished earnings and the ultimate loss of the already steadily decreasing private patronage. The Calgary General Hospital would appear to have lost so much prestige despite the excellent medical and nursing service given that only strong measures can restore it to public favour. It is understood that a sum of some $125,000. is now available for the Hospital from the Perley Estate. It has been suggested that this sum might be used for the erection of an obstetrical building separate but adjacent to the General Hospital. Such would seem to be a very logical and much needed use for this money. Any decision appertaining thereto is beyond the province of this Report, but it is suggested that, as this sum would not build a modern unit of more than thirty to thirty-five beds - without equipment - some thought should be given to the desirability of adding more separate units. Moreover, no unit should be put up until a definite decision has been made as to the future site of the Hospital.

Equipment - It is recommended that additional equipment be added as rapidly as finances permit. The choice of the clinical equipment can be determined largely by the appropriate committees of the medical staff. Present needs include, for instance, a gas-oxygen machine for the operating room; to ensure its proper maintenance and skilful use, such should be used only by anaesthetists properly trained in gas administration. An oxygen tent is also required.

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B. - MANAGEMENT AND ADMINISTRATION

The basis of control of the Hospital is described on pages 3 and 4. The present type of management would seem to be an excellent one. Direction by a Hospital Board is much preferable to having the Hospital placed directly under the City Council for two major reasons - the Hospital should be kept absolutely divorced from municipal politics, which is an ever present danger when candidates stand or fall on their record of hospital management, and hospital management requires so much experience that considerable continuity of membership is essential. It is well, of course, that the Council be represented on the Board, but the choice of citizens at large is commendable as is also the arrangement for a two-year term. In any opening up of the Hospital Act, this period might well be raised to three years, two being appointed each year.

Under no circumstance should the members of the Board be elected rather than appointed as at present. Sad experience has amply proven that this invariably makes the Hospital a political football. Moreover, it is highly desirable that the Board be let alone. It should stand or fall on its own policy and efforts to drag it into politics should be strongly resisted.

As the management of the hospital must provide not only financial direction, but must make adequate provision for the care of sick people, some arrangement must be made for correlating the administrative and the medical aspects of the work. The Standardization Committee of the Medical Staff acts as an advisory body to the Hospital Board. In addition the Chairman of this Committee, who is also the President of the Medical Staff, attends the meetings of the Board in an advisory capacity. This arrangement would appear to be mutually satisfactory.

Administration:

The municipal hospitals are administered by a Medical Superintendent, Dr. William H. Hill, D.P.H., and by a Business Manager, Mr. James Barnes. The Medical Superintendency is a part-time appointment, Dr. Hill's major appointment being as Medical Officer of Health to the City. Mr. Barnes' appointment is on a full-time basis.

The present arrangement does not seem to be a very satisfactory one; at least it is not working out as obviously intended. The Medical Superintendent would seem to be a general superintendent inname only. The actual administration is almost entirely in the hands of the Business Manager. This is largely because Mr. Barnes is in the Hospital all day long and has his finger constantly on all that goes on in the Hospital; Dr. Hill on the other hand is in the hospital each day for a short time only and has not the time along with his varied other duties to check over the operations of the various departments or to even keep in close touch with the multitudinous details arising each day.

Of particular significance would seem to be the observation that the Medical Superintendent does not even have an office where he can conduct his business or hold interviews. Such must now be done in the already overcrowded room now occupied by Mr. Barnes. The writer knows of no large hospitals in Canada providing such inadequate office accommodation.

MANAGEMENT AND ADMINISTRATION - (cont'd)

The Superintendent's present duties are:

Supervisor of the Dispensary
Consultant respecting the Training School
Certain medical signatures
Certificates of emergency
Physical examination of probationers
Consultant to Staff on medical problems
Lecturer in Public Health to the nurses
Arbitrer respecting doubtful rashes, etc.
Consultant respecting medical equipment
Sanction required for therapeutic abortions
Sanction required for thyroidectomies
Liaison officer between the Staff and the Board.

Either there should be a Medical Superintendent or there should not be one. Except as outlined above, Dr. Hill is now but a fifth wheel to the General Hospital. He cannot take active steps when a member of the professional staff disregards the Hospital rules for fear of losing professional support and patronage. He cannot give the strong medical leadership to the institution which the situation requires. It was noted that even professional regulations posted in the Hospital were signed by the Business Manager. Personnel are subject to the Business Manager, not to the Superintendent. The Superintendent apparently cannot dismiss an orderly. This puts Dr. Hill in an unnecessarily weak and unenviable position.

As for the Business Manager, Mr. Barnes, my impression was that he had an exceedingly good grasp of the many problems of hospital administration. The writer was particularly pleased with the wealth of detail which was available on a moment's notice respecting any aspect of the operation of the Hospital. Actually, I have never conducted a survey in which I have been so inundated with studies, tabulations, reports and other data. Particularly has he an intimate knowledge of the service departments of the Hospital. Mr. Barnes' obvious ability as a business manager would warrant his retention in any revision of the administration.

To attain maximum efficiency the part-time Medical Superintendency should be converted into a full-time appointment. The situation warrants this change. The direction of the Health Department of a City the size of Calgary warrants a full-time man and therefore there should be no reduction in Dr. Hill's salary - already minimal for this work - because of the diversion of his entire time to public health affairs. It is doubtful if any other part-time medical superintendent would meet the situation. True, Dr. Hill might take a somewhat more aggressive attitude towards the administration of the Hospital, but any part -time superintendent would find himself seriously handicapped in directing the Hospital and were he in medical practice his relationships with his colleagues would not be any easier.

The following alternatives are suggested, in the order of preference:

1. Full-time Medical Superintendent.
   Business Manager to take over the purchasing department as well.

2. Make the Business Manager the General Superintendent, and appoint a Medical Superintendent to look after professional affairs only.

MANAGEMENT AND ADMINISTRATION - (cont'd)

1. - The first alternative - a full-time medical superintendent - would be the best arrangement. One does not desire to raise any controversy over the question of whether the superintendent should be a doctor or a layman; each has a different approach to a complex position and each group has contributed many highly successful administrators. In this particular instance, however, where the hospital has an "open" staff and where there is need of better medical esprit-de-corps, a carefully selected full-time medical administrator would be a distinct advantage. Mr. Barnes would retain his position as Business Manager with a realignment of his duties, a better title being "Assistant Superintendent and Purchasing Agent". The only real difficulty with this basis would be the [illegible]ofactor of somewhat added cost, for the right administrator would not come for a pittance. However, he should be able to return the difference by added efficiency and sundry savings.

Were the Hospital a 300 bed hospital, the decision would be an easier one, for the hospital is somewhat small for a full-time medical superintendent.

The Standardization Committee of the Medical Staff has submitted the following statement:

> "While the Committee has no intention of making any criticism of the existing practice of conbining the offices of the Medical Superintendent of Hospital and the Medical Health Officer of the City, it is considered that, having regard to the size of both the Hospital and the City, the position of Medical Superintendent should be held by a full time medical man having some experience of hospital organization and management but such appointment not necessarily to eliminate that of Business Manager of the Hospital."

2. - The second alternative - the appointment of the Business Manager to the Superintendency - would more effectively enable him to do what now crosses his desk. With greater authority he would feel free to make more definite decisions. While there is no doubt about Mr. Barnes's ability as a Business Manager, it would be for the Board to decide whether or not his ability to formulate broad plans of development and to gain the fullest co-operation of the general public and the medical profession would warrant his appointment to the General Superintendency. Certainly with his intimate knowledge of the local detail, it would be a good outside appointee who could give better service.

As the weakness of such an arrangement would be the professional direction of the Hospital, it would be necessary to appoint either a part-time Medical Superintendent or to have an active Medical Advisory Committee to whom all matters affecting the professional or clinical arrangements could be referred. Who-ever would accept the appointment of part-time Medical Superintendent must have the fullest co-operation of the doctors; moreover such person must be prepared to make definite decisions and to stand by those decisions. Such individual must understand thoroughly the doctors' viewpoint, yet must be so independent that he can never be accused of serving the interests of his private practice by his actions. Therefore such individual must be carefully chosen. Theoretically, the part-time appointment of the Medical Officer of Health would seem ideal; practically it would appear that his major responsibility prevents him from giving adequate direction to the work at the General Hospital. Possibly a rearrangement of his other duties would make this possible.

C. NURSING SERVICE

The nursing complement is normally 116. This is made up as follows:

1 -	Superintendent of Nurses (Miss Sadie MacDonald)
1 -	Ass't. Supt. of Nurses (Miss Anna Hebert)
1 -	Instructress (Miss Jessie Connal)
1 -	Operating Room Supervisor (Miss Julia Murphy)
9 -	Supervisors, O.R. assistant, etc.
103 -	Student nurses (including two affiliates)
116 -	Nursing Complement (less 3 - administrative and teaching)

The Superintendent of Nurses joined the Staff in 1911, becoming Assistant Superintendent of Nurses in 1917 and Superintendent in 1923.

Her Assistant, Miss Hebert, graduated from this Hospital in 1913. She was Night Supervisor for seven years and became Assistant in 1923.

The Instructress, graduated from the Royal Infirmary in Glasgow in 1914, had five years war service, was on general duty 1919-21; Supervisor in 1921-23 and Instructress since 1923.

The Operating Room Supervisor has held her position for some 27 years.

The Operating Room Assistant, who graduated from this Hospital in 1933, is not a registered nurse. While not absolutely necessary, the possession of such R.N. qualification is highly desirable and is required of all graduate nurses in most hospitals.

Postgraduate Training - It is of some significance that there is not a single nurse in the hospital who has had any real postgraduate training in the work which she is doing. The Superintendent of Nurses and her associates are to be commended for the excellent efforts which they are making for they have not been given any opportunity to gain new knowledge or inspiration from special or refresher courses. The Superintendent has only had a short period of hospital visiting quite a few years ago; her Assistant has had no experience in any other hospital; the Instructress is reported to be an excellent teacher despite the fact that she was not especially trained for this highly important work. Beyond one or two weeks' observation some years ago the Operating Room Supervisor has had no postgraduate training since she took over the work 27 years ago.

There is one scholarship of $150.00 available for postgraduate work for graduates of the School for Nurses, but this is frequently not taken up (through lack of other funds required) and, of those who have taken the scholarship, only one, Miss Harvey, '30, has come back to the Staff.

This lack of postgraduates is not a good thing. Nursing today has advanced to the point where, just as in medicine, extensive postgraduate study is necessary to master various fields and keep abreast of the times. Even ward supervision is now recognized as requiring special knowledge and training and the use of young graduates, and occasionally senior students, for supervisory work is unfair to both patients and student nurses. Such should be employed for floor duty only. The use of senior students as supervisors may teach responsibility but it is a dangerous practice and unjustifiable in case of a negligence suit.

NURSING SERVICE - (bont'd)

It is recommended that no nurses be added to the staff (except for general floor duty) who have not had postgraduate training elsewhere. Moreover all future appointments should go to the applicants holding the best qualifications, irrespective of local affiliations. Naturally other things being equal, graduates of the Calgary General Hospital should be given preference, but "in-breeding" has ruined the efficiency of many hospitals and a plentiful supply of "outsiders" is very stimulating and beneficial.

Also those now on the staff should be not only encouraged but be required to take frequent refresher courses. For instance, the Superintendent of Nurses and her Assistant should take (in alternate years) the two-weeks Administrators' Course given by the American Hospital Association and the University of Chicago. This should be taken by the Business Manager also. The refresher courses given by the Schools of Nursing in the Universities of British Columbia, McGill or Toronto, should be attended whenever possible by the supervisors. The provincial and other nursing and hospital conventions should be attended in greater numbers than hitherto. Hospital journals should be freely available for one idea gleaned would pay for the subscription many times over.

Can the Nursing Staff be Reduced?

At the present time the nurses work a 56-hour week if on day duty and a 73-hour week if on night duty. Students (not graduates) work an 8-hour day and receive three weeks' holidays annually.

The average for the course (day duty outweighing night duty) is 58 hours per week. This is practically the same as the average at Holy Cross Hospital, which is 58½ hours, but is higher than at the Royal Alexandra Hospital and at the University Hospital of Edmonton, where the average for the period of training is 52 hours.

Nursing Ratio: The patient-nurse ratio in a number of somewhat similar hospitals is as follows:

	Capacity	Average Census	Actual Nursing Staff	Patient-Nurse Ratio
Calgary General Hospital	215	200	113	1.8 pts. per nrs
Holy Cross, Calgary	275	155x	105	1.5
Royal Alexandra, Edmonton	510	366	197	1.8
University Hosp., Edmonton	365	275	118	2.3
Ottawa Civic Hospital	600	475	236	2.1
Regina General Hospital	368	252	152	1.6
Saskatoon City Hospital	304	201	117	1.7
Victoria Hospital, London	454	312	175	1.8
Royal Jubilee, Victoria	330	230	131	1.7
Moose Jaw General Hospital	190	115	56	2.0
Hamilton General Hospital	665	465	292	1.6

x Figure submitted in analysis for approval for internship.

As the various references consulted gave varying figures for capacities, nursing staffs, average census, etc., the above figures are to be taken as approximate only. This ratio is calculated in so many different ways, that, to make figures comparable, certain deductions had to be made from some of the data obtained.

In an extensive analysis of 1196 hospitals, Dr.M.T.MacEachern found that, in the group having 100-249 beds, the ratio was .65 nurses per patient, or to convert to the basis used here, a patient-nurse ratio of 1.5 patients per nurse.

NURSING SERVICE - (cont'd)

The above table reveals that the Calgary General Hospital is neither the highest nor the lowest in its ratio of patients to nurses. The nurses do serve more patients than in the extensive study by Dr. MacEachern. The unusually low ratio at the Hamilton General Hospital (i.e. low proportion of patients to nurses) may be due in large part to the large out-patient department requiring nursing attendance. Regina General Hospital has long been known to be understaffed. However, in view of the very limited call on nursing service for out-patients and emergencies at the Calgary General Hospital it would appear from these figures that the Hospital might be overstaffed with nurses.

Before accepting this conclusion, certain extenuating factors must be considered:

(a) The Hospital is so badly laid out that the labour of performing nursing services is much greater than in any of the hospitals mentioned above. The lack of adequate plumbing, utility services, etc. are particularly wasteful of time.

(b) As there are very few private patients, there are fewer "special nurses" to help with the nursing than in other hospitals.

(c) The shortage of beds means that many patients must be moved, three and even four times before being finally settled. Nursing is always harder when the census approaches capacity.

(d) Nurses are required to carry food trays. In many hospitals maids, or ward aides, do this work.

(e) With over 100 doctors on the staff, the time required to attend doctors is greatly increased. (However, many of the above are "open" hospitals.)

(f) The eight-hour dayfor student nurses adds to the personnel of the nursing staff.

(g) There are no interns. Such would relieve the nurses of many duties now required of them.

(h) Actually the nurses are now seriously shorthanded at times. The obstetrical night staff often is quite inadequate. For instance, only 43 nurses were on duty in the Calgary General Hospital on the day of this study.

(i) The Isolation withdraws varying numbers of nurses for many months of the year.

(j) Most of the other hospitals gain the services of appreciable numbers of "affiliate" students from smaller schools of nursing.

(k) Under the present 5-day arrangement, graduates are off 1⅔ days a week. This means greater loss of nursing service than in other hospitals.

Undoubtedly these factors will prevent the hospital from ever achieving a very satisfactory ratio of patients to nurses. The writer is not convinced that the ratio can be reduced under the present circumstances without impairing efficiency. Nevertheless, as there is no out-patient department and the nurses are saved the delays associated with a University service, it should seem possible to make certain reductions. Such would depend upon one or more of the following factors:

NURSING SERVICE - (cont'd)

(a) A careful analysis of the duties and responsibilities of each member of the nursing staff.

(b) Improved utility and other patient services, signal systems, etc.

(c) More skilled personnel for supervisory and other vital appointments.

(d) The greater development of standard and routine medical procedures.

(e) Some improvement in the morale of the personnel and possibly more aggressive leadership in the nursing division.

(f) More appreciation of service rendered by the Superintendent of Nurses and her nursing staff. The nursing atmosphere seemed to lack inspiration.

Should pupil Nurses be Paid?

Student nurses at the Hospital receive the following honoraria, plus books and uniforms:

1st year - (second six months)	$ 6.00	per month
2nd year -	10.00	" "
3rd year -	15.00	" "

It has been customary to pay student nurses nominal salaries, but in recent years this policy has been seriously questioned, particularly as many of the less professional duties are being assigned more and more to aides and maids. True, this little sum has often proved a life-saver to poor girls, but students in other courses pay fees rather than receive salaries and such may be just as deserving individuals. The training of nurses is now less of an apprenticeship and more of a definite professional course.

The students' honoraria should either be abolished or cut in half.

While this sum might be credited as a saving, it would be most justifiable to put this back into the Training School. There should be another instructress and the equipment, while reasonably good, should be better.

Further Comments on the Nursing Service

The suggestion of arranging for the exchange of supervisors is exceedingly good. Any inconvenience is more than offset by the new ideas received.

The comment made by more than one person that supervisors should have been away from the Hospital for at least two years to break social affiliations is in accord with the psychology of maintaining discipline in any institution.

Many complaints were received about the service in the operating room. It seemed agreed that the supervisor was competent and conscientious, but in need of postgraduate brushing up. Complaints were made about the frequent changing of the assistant. However, the present assistant is now on a "temporarily permanent" basis.

The employment of untrained recent graduates on 2nd East and 2nd West at $30.00 a month is a doubtful economy. Such appointments should be filled by properly trained supervisors. The additional cost would be quickly returned by more efficient nursing service in general.

NURSING SERVICE - (cont'd)

Nobody seems to be in training for the position above. This is not healthy.

The Superintendent of Nurses should have a private dining room. This is only in keeping with the dignity of the appointment and is desirable for meal time conferences, use of guests, etc.

There would seem to be adequate efforts made to check the health of the nurses. The average number of days of sickness had gone up from 8.97 in 1935 to 13.17 for the first half of 1936. This increase has been explained as due to greater contact with scarlet fever, for which disease preventive measures are not as effective as for diphtheria, smallpox and other dieases.

D. OTHER PERSONNEL

In addition to the administrative, nursing and specialist staffs, the Hospital has the following personnel:

	Office		Salary	Extras
1	Accountant		135.13	1 meal
1	Investigator (collection) (10% of collections)	(avge)	89.33	
3	Stenographers		81.90	
6½	Other office staff	45.00-	81.90	1 meal
	Dietary Department			
1	Dietitian		85.99	B & L
1	Ass't. Dietitian		6.00	B & L
6	Chef, cooks & kitchen men - Chef		126.53	½ meals
	others - others		77.80 to 96.63	½ meals
6½	Maids (D.R. & D.K.)		45.05	B.
	Boiler Room			
6	Engineers		161.75	
	(Two on part time only)	three at	122.85	
	part time at -	65.00 &	85.00	
	Laundry			
1	Foreman		114.25	
9	Others	50.00 to	94.19	
	General			
1	X-ray Technician (plus one voluntary)		97.27	
3	Pathological Technicians		69.60) 72.07) 96.65)	3 m.
1	Druggist		151.50	
2	Matrons (N.Q.)	25.00 &	58.55	B & L
6½	Orderlies	90.10, 94.18,	106.47	B & L
4	Linen Room	46.68	77.80	B & L
1	Floor Polisher & Cleaner		90.10	
1	Plumber & Repair Man		139.23	
1	Carpenter		131.04	
1	Painter		122.85	
5	Porters & Elevator Men		90.10	
2	Stores Department	94.16	147.42	
	Maids		45.05	B & L

With the 117 2/5 staff mentioned in the opening sentence above and already listed (omitting the part-time pathologist and radiologist), the entire staff is 188 (actually 187 9/10).

Is the Personnel Too Large?

The above staff (total) of 188 is maintained for an average patient census of 200. In other words the patient-personnel ratio is 1.06. A comparison with other somewhat similar hospitals is as follows:

OTHER PERSONNEL - (cont'd)

Hospital	Average Census	Total Personnel	Patient-Personnel Ratio
Calgary General Hospital	200	188	1.06 pts. per person
Royal Alexandra, Edmonton	366	385	.95
Regina General Hospital	252	301	.83
Saskatoon City Hospital	201	248	.81
Victoria Hospital, London	312	372 (plus boiler plant staff)	.84
Moose Jaw General Hospital	115	95	1.21
Hamilton General Hospital	465	524	.88

In Dr. MacEachern's study, mentioned previously, hospitals of this size (selected to minimize incomparable factors) averaged 1.06 total personnel per patient, or, as compiled above, a ratio of .94 patients per employee.

From the above table it will be seen that only one hospital - the Moose Jaw General - has a smaller staff in proportion to the patients served. In view of the handicaps due to obsolete plant and poor equipment and the 5 day week, it would appear that the Calgary General Hospital on the whole is not overstaffed.

This statement, however, must be taken with care. It must be borne in mind that the Calgary General Hospital does not provide a complete service. The following services, if given fully, would add to the staff definitely:

(a) O.P.D. lacking
(b) Records Department very inadequate. No record librarian.
(c) No social service.
(d) No intern service.
(e) Very meagre admitting service.
(f) No housekeeper.
(g) Stores department shows minimum organization.
(h) Office staff inadequate.
(i) No pharmacy assistant to make up solutions, etc.

Dietary Department - One dietitian and assistant (summer only) are needed. The staff of six cooks and kitchen men would seem normal in view of the five-day week and the eight-hour shifts. The work is complicated, too, by the top floor location away from the main stores, and the refrigerator on the ground floor, the inadequate elevator service, the hand-powered dumb-waiter and the absence of the usual kitchen equipment such as a dishwasher, potato peeler, an electric food mixer, etc. One man is required to go to the nurses' cafeteria to serve dinner. This frequently leaves the kitchen uncovered. The night staff consists of one woman.

Approximately one third of the diets to patients are special diets from the Diet Kitchen. These are not put on the lifts but are distributed by the elevator. This is a slow method, but owing to the limited lift service a change is not recommended. During the past decade the use of special diets has increased tremendously in all hospitals.

There are some 6½ maids assigned to the Dining Room and the Diet Kitchens. One maid serves the top floor dining room. She served 29 for lunch on the day this Department was studied. The Diet Kitchen maids are under the Sewing Room direction. More unified control would seem desirable.

In April, 33,440 meals were served, of which 18,528 were patients' meals. The raw food cost was 9.33 cents per meal - a figure somewhat below the average.

OTHER PERSONNEL (cont'd)

Boiler Room Staff: There are now six engineers. As two men work part-time only, the complement is more accurately described as of five men. The Boilers Act, 1929, sec. 23, requires that any boiler carrying a working pressure of twenty pounds or more shall be "under the immediate continuous supervision of one or more engineers who are holders of valid certificates under this Act". Under clause (b) of this Section it is required, for plants of this h.p. that the Chief Engineer shall hold Second Class papers and any assistants in charge shall hold at least Third Class papers.

All of the assistants here have Third Class certificates including the part-time men. Apparently no firemen can be employed, as the five-day week and eight-hour shifts require all of the staff to be in charge at certain times. Were no steam required at night and the fires could be banked, it is presumed that firemen could be used on the night shift, as outlined in Section 27 of the Act.

The staff looks after the refrigeration plant and does the plumbing and repair work when the one plumber is off duty, which, of course, is more than two-thirds of the time. The engineering staff also does a great deal of the welding, etc., required for various hospital equipment.

Under the present circumstances, it seems difficult to say definitely that one engineer less would suffice. Were there not a five-day week, this would seem possible, but, under the present schedule, there are many times when emergency calls in the various parts of the Hospital require leaving boilers unattended for short periods. Because of the old plumbing throughout the Hospital, repairs are frequent and cannot be neglected; moreover, with no reserve boiler, plant efficiency must be maintained at all times.

It should be pointed out, however, that the present staff could as readily take care of the needs of a hospital fifty per cent larger.

The use of low pressure rather than high pressure steam as suggested would permit a reduction of the staff and a substitution of certain of the staff by men with lower papers. Whether or not this would warrant the change would depend upon the cost of the change, the ultimate cost of operation and the rearrangement required for the laundry and the sterilizers. Such would have to be referred to an engineering expert who could make a detailed study of the estimated costs. (See also under Physical Plant).

Orderlies - There are five on day duty and two on at night, although the five-day week and the eight-hour day spread the coverage considerably. One orderly is listed as part-time only. This would seem like a minimum complement; it has been checked with the roster of other large hospitals and found to be well below the average.

The orderlies here do more varied work than in most hospitals, probably because of the lack of interns. For instance, they do about 95 percent of the catheterizations, do bladder irrigations, do hemorrhoidectomy dressings, handle all rectal injections and Murphy drips and look after venereal cases. They also prepare male patients for operation, take off casts and usually assist in putting on larger casts. They are in charge of the electric heat tent, baths, etc. They help prepare and remove bodies of deceased patients.

Of the above seven, one is in the operating room and one is relief orderly. There is one orderly for about 80 male patients - a low ratio. Except from 7 a.m. until 12 noon there is only one orderly on duty and the absence of anadequate signal system means much loss of time. The operating room man is quite busy and at nights, when there is usually but one man on, the calls to the operating room may leave the entire hospital uncovered for orderly service for up to an hour or more.

OTHER PERSONNEL - (cont'd)

In Dr. MacEachern's study of a large number of hospitals, he found approximately one orderly for every 25-30 patients by day and for every 40-50 by night.

One annoyance from the service viewpoint is that orderlies, in conformity with union regulations, walk off at five o'clock. As doctors and nurses must carry on until the work is done, the shortage of orderly service at times is the more obvious.

There has been very little change in the service. Four of the men have been employed for 6, 7, 14 and 16 years.

The head orderly is in charge of the splint room. Such procedure would not be entirely satisfactory were the head orderly not so obviously a competent man. However, the system falls down somewhat in that there does not seem to be an adequate routine for the reclaiming of borrowed splints. (See also note under Salaries)

Laundry - The staff of a foreman and nine others is well below the average personnel-patient ratio of the other larger hospitals consulted. The cost per piece - the usual basis of comparison - could not be obtained.

Office Staff - The present staff is made up as follows:

1 Accountant
3 Stenographers
2 A & D Clerks (2 shifts)
2½ Switchboard operators (3 shifts)
1 Junior Clerk
1 Collector (outside)
1 Ledgerkeeper

11½ - one being part time.

There is now an extra junior temporarily employed to catch up on the correspondence respecting collections. All of the staff are on the five-day basis which is very unsatisfactory, causes much confusion and delay and means a great deal of unavoidable over-time.

In comparison with other large municipal hospitals the following tabulation is of interest:

Hospital	Average Census	Office staff including records and switchboard.
Calgary General Hospital	200	11½ (or 9 - see above)
Royal Alexandra, Edmonton	366	21½
Regina General Hospital	252	13
Saskatoon City Hospital	201	16 - 17
Victoria Hospital, London	312	14
Hamilton General Hospital	465	14

From the above, this Hospital would appear to have a staff somewhat below the average ratio. The Hamilton General Hospital has a relatively smaller staff; on the other hand the Royal Alexandra Hospital and the Saskatoon City Hospital have relatively much larger office staffs. The shortage is really more than shown here because of the five-day week and the lack of special accounting machines. The work is greatly augmented, too, by the shortage of space which requires additional handling and disposal of all current files each day. There is also greater confusion and consequent distraction and loss of time. It was noteworthy that until recently the office was three months behind in getting out accounts. With an added stenographer, there has been some catching up, but on June 12th the office was still getting out accounts which should have gone out May 24th. Holidays usually mean overtime and night work for the others on the staff or the individual on her return.

OTHER PERSONNEL - (cont'd)

Public criticism is said to be affecting the morale of the staff.

Medical records are handled by the admissions clerk and the switchboard operator - a very unsatisfactory arrangement which is discussed later in this report.

A reduction in the office staff cannot be recommended. The quarters should be increased and a records clerk, at least, added.

Stores - There is a storekeeper and a bookkeeper. Stock is kept on open shelves in a storeroom one floor up from the receiving entrance. Dressings are kept elsewhere and meats are delivered to a refrigerator on the ground floor. The storekeeper purchases all except drugs and medical instruments, although the latter go through his hands. The stores staff does much of the portering. Most of the food is handled at least twice. No perpetual inventory is kept. One official inventory is made annually and one every three months for the use of the stores staff.

Stores are issued on requisition only, requisitions being countersigned by the Business Manager.

No reduction in staff can be urged here. More consolidation would simplify the task, but any time saved should be utilized to develop a better organization and to maintain a perpetual inventory.

Were an earlier suggestion made under "administration" adopted, the Business Manager would be more directly responsible for the purchasing.

Labour Unions - Certain of the employees are organized into "locals" in the Federation of Civic Employees. They negotiate as a unit in respect to wages. It is understood that the following groups belong to such: laundry workers, porters, clerks, painters, maids, orderlies, kitchen staff, elevator men. The engineers are not organized as a city local but belong to their own trades union.

Valuable as unions are and necessary as they have been at times to gain proper wages for their members, their place in the hospital is open to question. Hospitals are dealing with Life itself and no organization which would permit a strike or which, for partisan reasons, would prevent the dismissal of an incompetent employee, should be permitted to jeopardize the safety of the sick of Calgary. Assurance was given that the "locals" have no intention of ever interfering with the safe operation of the hospital and the point is raised here, largely because of the desirability of emphasizing this necessity, but also because there was definite inference that the unions have at times endeavored to exercise pressure upon the hospital management.

Summary - The duties of the other members of the service personnel were checked. Two matrons are necessary for the nurses' quarters because of the scattered housing. The roster of porters and elevator men is normal for the requirements. Under the circumstances of the present buildings and equipment, further reductions would seem possible only at the definite risk of impairing efficiency.

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E. COSTS

Salaries and Wages:

These are as outlined on pages 37 - 38. In addition the following, omitted in that list, should be added.

		Monthly	Extras
Medical Superintendent	P.T.	133.35	
Business Manager		221.67	
Radiologist	P.T.	90.00	
Pathologist	P.T.	159.70	
Supt. of Nurses		135.13	B & L
Asst.Supt. Nurses		110.54	"
Night Supervisor		93.36	"
Asst.Night Supervisor		73.71	"
Instructress		93.36	"
Supervisors, Maternity & O.R.		93.36	"
Asst. Supervisor O.R.		77.80	"
"Scrubbed Nurse" O.R.		30.00	"
Floor Supervisors	2 at	30.00	"
	1 at	77.80	"
	1 at	81.88	"
Nurses in training	-	6.00	"
		10.00	"
		15.00	"

While the Isolation Hospital is being considered separately, the salary list is included and discussed here.

		Monthly	Extras
1 Lady Superintendent		102.37	B & L
Graduate Nurse (s) (1 part time for portion of year)		77.80	"
1 Laundress & Maid		30.00	"
Additional laundress and maid	P.T.	30.00	"
1 Porter and Laundryman		81.90	1 m.
1 Cook		45.00	B & L

Other nurses, - pupils paid as at Calgary General Hospital

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A comparative study of this salary list was made. In doing so, due appreciation was made to the five-day week, an arrangement seldom followed in hospitals. Two reductions of 10 per cent and 9 per cent have already been made. On the whole the schedule conforms fairly closely to the common experience among hospitals. Unfortunately hospital salaries in general are decidedly low considering the training required for most of the positions, the importance of the work and the potential danger to health.

Most of the salaries are in accordance with the agreement between the City of Calgary and the City Hospital Employee's Association Local Union No. 8, made on March 1st,1929, less reductions of 10 per cent and 9 per cent.

Certain salaries are distinctly below the average. The Medical Officer of Health is underpaid considerably in view of his training and responsibilities as guardian of the City's health. The $30.00 paid to certain floor supervisors would be too low for floor duty, much less the responsibility of supervision and instruction. The radiologist receives such a small honorarium that unbounded enthusiasm could hardly be anticipated. The operating room supervisor usually receives more than is given here - also her assistant.

costs - cont'd)

Other items seemed to be above the average. Kitchen assistants at $77.80 (the three cooks are paid higher salaries) exceed the usual rate. The stores assistant at $94.16 is well above the average, as is the floor polisher at $90.10. Orderlies at from $90.10 to $106.47 per month and board and lodging are considerably above the average, especially for a five-day week; it is claimed, however, that these men do more than the average orderly (which is true) and that orderlies as a class are notoriously underpaid. The honoraria to pupil nurses has already been discussed. While maids are paid more than the average, 10 per cent of the wage is in lieu of room. These wages must conform to the Minimum Wage stipulations.

On the whole the salary list would appear more "evened out" than in the great majority of hospitals. The more skilled and responsible positions would appear to receive below the average remuneration and the less skilled and responsible positions above the average.

Dietary -

The raw food cost for 1935 of 9.3 cents per meal is below the average, which runs from 9.5 to 10 cents or a little higher. Food is mostly choice or standard - the usual hospital policy.

The proportion of meals served to personnel is lower in this Hospital than in most hospitals. This is largely because so many of the personnel do not receive many, if any, meals. Under such circumstances it has been found in some hospitals that quite a few "extra" meals are taken and meal tickets have been instituted as a safeguard. This is not more than mentioned here for assurance has been given that only those meals are given for which agreement calls.

Food supplies would seem to be adequately controlled. The cook gets supplies from the Dietitian, who in turn requisitions them from the storekeeper. Employees are prohibited from removing any supplies from the kitchen. The stock in Daily Stores, which is open to the kitchen staff, is small and the amount used is constantly checked by the Dietitian with respect to the number of meals served. A maid is responsible to the Dietitian for any issues supplied to the Ward Kitchens.

Costs could be lowered by more labour-saving equipment, both in the kitchen and in the food transportation.

Fuel -

The increased economies in fuel have already been mentioned.

Analysis of the Per Diem Cost -

Mr. Robert Newstead, the accountant, has prepared the following analysis of the per diem cost for 1935:

Administration charges	$ .209
Nursing services	.483
Medical and surgical supplies	.197
Department expenses	.953
General house and property	.537
City overhead charges	.201
	$ 2.580

These figures are not out of the way. However, 19.7 cents for medical and surgical supplies seems lower than the average.

Salaries are 48 per cent of the entire expenditure and nursing care 19 percent. It is rather difficult to compare the data submitted with the many figures filed in our reference library, inasmuch as few hospitals make exactly the same breakdown in analyzing their figures. However, as it is generally agreed that no hospital should spend more than 50 per cent of its total expenditure on salaries, and as this hospital does not have services frequently found in hospitals, it is getting close to this maximum of 50 per cent. The nursing breakdown of 19 per cent would seem lower than the average.

F. FINANCE

Revenue and Expenditure

The financial sheets for 1935 for the Hospitals Department (x) reveal the following totals:

(x - In earlier chapters of this Report an endeavor has been made to consider the Calgary General Hospital apart from the Isolation Hospital, but in this chapter the figures as submitted usually cover both institutions.)

Expenditure -	$ 240,630.96
Revenue	185,532.96
Charge to Mill Rate	$ 55,093.00

In addition to the above mill rate charge to Calgary there is the sum of $50,000.00 paid to the Hospitals Department for the care of indigent patients. The total cost to the City of Calgary, therefore, is $105,098.00. Is this too high a price to pay, or does the City get a fair return for its expenditure?

If the patients be considered as to whether they come from the City or elsewhere, the proportion for 1935 was:

	Calgary General	Isolation
City of Calgary	4,739	194
Elsewhere	1,081	11
	5,820	205

The ratio of nearly 5 to 1 has prevailed for some years back. For the Isolation Hospital, as would be anticipated, a much higher ratio is found.

When we consider the proportion of private and ward patients in the Calgary General Hospital, we find for 1935 the following patient-days:

Ward	City	Elsewhere	Total	Percentage of grand total
General	48,503	15,166	63,669	87.3%
Semi-private	5,645	961	6,606	9.0%
Private	2,305	573	2,878	3.9%
	56,453	16,700	73,153	

The total city business is 77.1 per cent of the entire number of patient days.

In the general wards no differentiation is made as to who are non-pay and who are part-pay. However, the City indigents represented a known lost revenue of $62,264.00. Actually this was less than cost, for it was calculated on a basis below the actual cost of service given.

To offset this cost for Calgary indigents of at least $62,264.00, the City contributed $50,000.00. Were there no municipal Hospital and were the City to pay such other hospital (s), the statutory rate only, the cost would have been approximately $62,264. inst ead of $50,000. Therefore, in calculating what it costs the City of Calgary to operate a civic hospital, the calculation should be: $105,098. less $62,264. or $42,834.00.

FINANCE - cont'd)

This is stilla large sum of money and citizens rightly ask if it be necessary. We must keep in mind that our people are healthier and live longer than ever before. We owe to the hospitals and their staffs a large share of this credit.

With the advance in medical science hospital care is costing more, but it is coming back to us in better diagnosis and better care. The General Hospital has a negligible private ward and a large general ward patronage. No hospital under a voluntary Board could possibly make ends meet under such circumstances unless blessed with tremendous endowment. In many cities voluntary non-municipal hospitals are having their deficits met by the city in addition to the payment of the statutory grant. This is done to keep the hospitals from closing their doors. In Toronto, for instance, where none of the general hospitals are municipally owned, the City pays not only the statutory per diem rate but pays the hospitals large sums at the end of the year to help them cover their substantial deficits. The earlier history of the Calgary General Hospital revealed the difficulty faced by a voluntary Board in financing the Hospital.

While the amount paid directly to the Hospital Department in 1935 was $50,000.00 in contrast to $25,000. for the three previous years the mill rate charge was but $55,098.00 as compared to $81,569.52, $81,968.02, $96,676.89 and $114,109.84 as in preceding years. Back in 1923 when the indigent allowance was but $14,062.00, the mill rate charge was $182,933.47, the total cost then being $196,995.47 as compared to $105,098.00 today. Yet the Hospital is giving Calgary more service than ever before.

Analysis of Revenue

An analysis of the revenue statement for 1935 is as follows:

General Hospital		
City General Wards	$ 16,463.67	
" Maternity "	5,777.10	
" Semi-private wards	11,159.75	
" Private Wards	8,899.75	
Country General Wards	17,427.96	
" Maternity "	1,397.04	
" Semi-private Wards	2,030.70	
" Private "	2,832.10	
Operating Room	6,941.08	
X-ray	3,979.22	
Drugs	1,096.71	
Medical Supplies	152.73	
Pathology	1,078.38	
Spec. Nurses' Board	1,883.60	
Miscellaneous	88.42	81,208.21
Isolation Hospital		
City	26.00	
Country	403.70	429.70
Government Grant		
General Hospital	34,032.50	
Isolation Hospital	2,524.50	36,557.00
Accounts Receivable (patients)	9,384.75	
Adjustment to Reserve for Bad Debts	7,948.35	17,333.10
Indigent Patients	50,000.00	50,000.00
Miscellaneous	4.95	4.95
		$ 185,532.96

FINANCE- (cont'd)

This compares very favorably with a revenue of $151,870.07 in 1934 and of $144,385.51 in 1933. It is again approaching the high levels of 1927-1930.

Collections:

It was apparent that there is considerable difference between earnings and collections. While actual revenue exceeded the estimated revenue in 1935 by $17,124.96, the proportion of collections was not easily available. To obtain a reasonably accurate figure, Mr. Newstead kindly calculated the following data for the 1934 earnings:

Total of Accounts, paid and unpaid, apart from other revenue.....		$182,553.01
Collected as Current Accounts	$72,709.01	
Collected on 1934 accounts during 1935	11,033.55	
Total collections for 1934 and 1935 on earnings of 1934.....	$ 83,742.56	
Percentage of 1934 earnings collected during 1934 and 1935		45.8%

For the purpose of this study, the analysis might be made in another less startling way. The total of accounts in the table above is made up as follows:

Actually collected during 1934	$ 72,709.01
Listed as Accounts Receivable	37,296.43
Listed as Transient Indigents	2,639.06
Listed as City of Calgary	66,259.79
Hospital Employees' Accounts (free)	3,648.72
	$ 182,553.01

Several of these items such as transient indigents and hospital employees cannot be considered properly under the heading of "Collectuons" as collection from other municipalities for transients is very uncertain and the hospital employees are carried without charge. It is not stated whether or not the Calgary payment of $50,000.00 is included in the $72,709.01 or not. If so, the item of $37,296.43 for accounts receivable in comparison would seem by far too large; if not, the item is still too large but better than the alternative, particularly in view of the collections of $11,033.55 the subsequent year.

It was stated also that but about 40 per cent on the inclusive basis of the patients' earnings were collected last year. As stated above, this would not seem good enough, even in the present financial depression.

Two difficulties seem to be major factors. The first is lack of staff. Accounts have been very slow in going out and such is fatal to good collections. During the winter the staff was three months behind in sending out accounts - an absurd situation. The addition of another stenographer has helped a lot, but on June 12th accounts were just going out that should have gone out on May 24th. However, with the added stenographer some 1,261 accounts had been collected in the three months prior to this study - fifty-eight more than for the same three months the year previous.

The second need is for a more aggressive policy. Municipal institutions find it unusually difficult to collect accounts, for nobody expects them to be very vigorous collectors. There should be personal interviews before leaving the hospital, a friendly but firm understanding upon discharge, frequent and forceful letters, subsequent interviews and, if conditions warrant, no hesitation in undertaking

FINANCE - (cont'd)

legal procedures. The report on Collections of the Canadian Hospital Council, Bulletin No. 15, is heartily commended. This was written by the superintendent and collection personnel of the Saskatoon City Hospital, which institution has itself set up a fine collection record.

Some hospitals get regular reports on private patients from Dun's or Bradstreet's. They state that it pays.

The collector in 1935 collected $1,861.40. His salary and commissions amounted to $1,072.02, leaving a balance for the Hospital of $789.38. The question was raised, "Could a private agency do better?" There would be varying commissions of 15, 25 or more percentage, depending upon the age of the account. Such commissions could be charged to Expenditure. Office staff could be reduced also. Experience varies so widely that one would hesitate to make a recommendation. All would depend upon the reliability and routine policy of the agency. Under any circumstances increased effort should be made to collect accounts, for the net result is the same as though expenditures had been cut.

Hospitals have been having considerable difficulty collecting from farmers under the Farmers' Creditors' Arrangement Act. For some time the Canadian Hospital Council has been endeavoring to have hospital accounts placed in a preferred position. Recent advices from Ottawa would lead us to believe that early improvement in this situation may be anticipated.

Method of Financing -

The question was asked by the Board, Should the deficit be spread over all the citizens rather than leave it to the sole burden of the taxpayer?

Generally speaking the private patient pays his own way and usually a little more; the semi-private patient may or may not pay his way but almost does so; the public ward patient almost invariably receives more than he pays, or is paid for him. As most taxpayers (although far from all) take private or semi-private accommodation, they personally receive little, if any, return from the City's contribution. Most taxpayers apparently patronize the bther hospital when ill anyway.

There is a growing feeling that the cost of hospitalization should be spread over the entire community. The argument that those in the lower wage brackets cannot afford the added expense of hospital costs, loses much of its significance when one realizes that the cost of hospitalization, when spread over an entire community, does not exceed two or three cents per individual per day; moreover the average individual even though in straitened circumstances, spends far more than this trivial amount in tobacco, candy, movies, gasoline, clothes, sweepstake tickets and a host of other items.

The problem is how to raise the municipal contribution from other than taxpayers. A poll tax has been advocated in many cities; this, however, is costly to collect and becomes a nuisance.

A meal tax, as in Quebec, would not raise enough. A city-wide form of group hospitalization, as in Edmonton, Lethbridge, New York and many other centres would reduce the burden on the taxpayer to a considerable extent. It would hardly be on a compulsory basis, but a city-wide voluntary plan, strongly supported, would benefit all parties concerned. A booklet describing various such plans is affixed.

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G. THE MEDICAL STAFF

This Hospital has what is described as an "open" staff. Approximately one hundred doctors are members of the Staff, such being almost all of the doctors in Calgary. There is no division into active and associate staffs. Appointments are not on an annual basis, a doctor holding his appointment indefinitely unless for tangible evidence of negligence or imcompetence. Appointments are recommended by the Medical Staff and approved by the Board of Directors. The Staff is departmentalized to some extent - medicine, surgery, obstetrics, gynaecology, eye, ear, nose and throat, urology, orthopedics and paediatrics; however, such organization is very loose and the super vision of the work in the various fields is not at all thorough, the chairmanship of the various departments being largely a nominal appointment.

Staff meetings are held each month with a moderate attendance only. Attendance is not obligatory to hold membership. The Standardization Committee meets once a month.

The Medical Staff is not directly represented on the Hospital Board. However, the Chairman of the Staff is privileged to attend the Board meetings in an advisory capacity but without the ballot..

While the professional judgment and technical skill of the great majority of the Medical Staff is beyond reproach, there does seem to be lack of real interest on the part of its members. Nearly all members of the Staff are also on the Staff of the Holy Cross Hospital and quite a few stated frankly that the facilities and service were such at the Holy Cross Hospital that they were primarily interested in that institution. Moreover, the staff organization here is such that those doctors who are not at all interested in the General Hospital and who practically never send paying patients there, have as much voice in the Staff policy as those who are keenly concerned with the welfare of the institution. While a Court decision a decade ago may prevent the Hospital from selecting its staff, at least until the Hospital by-laws be amended, it might be possible to set up an Active and Associate staff without interfering with the "open" policy of the staffing arrangements.

While there was no suggestion made at any time that inferior medical work was being done because of lack of medical supervision, the potential danger always exists where the various surgical, medical, etc. committees do not feel free to exercise supervisory power over work done in their various Departments. This matter should be faced squarely by the Medical Staff and such powers given to the Departmental committees that will ensure none but the most efficient medical care.

At the present time the Medical Superintendent doubts that he has adequate supervisory power over professional work attempted. This doubt should be cleared up at once, for, while he will be guided without question by the Departmental committees, he should have the executive power in such matters normally vested in the medical superintendent.

Medical Staff Meetings - Greater effort should be made to build up keener monthly meetings. While many hospitals ensure good attendance by automatically demoting a doctor to the Associate Staff for missing, say, three - consecutive meetings without adequate reason, a much more effective method is to so improve the staff meetings that few will want to stay away. To be of a practical nature, with demonstrations, meetings should beheld in the Hospital, not uptown as at present.

The better type of staff meeting is not a haphazard affair. Such meeting requires careful planning. A Program Committee of enthusiastic young men should carefully review the available program material, preferably with the Standardization Committee, with which there could readily be interlocking membership. Those patients whose clinical

MEDICAL STAFF - cont'd)

history would be of general interest should be selected for discussion In conformity with the Standardization requirements, the death list should be carefully analyzed, and such cases as are unusual or for which more favorable results are usually experienced, should be selected. Any tissue removed or autopsy material should be prepared for exhibit and, if the doctor and patient be willing, the patient might be brought in to demonstrate a splint,or a skin or eye condition, etc.

It is of particular importance that each doctor associated with the various items on the program be personally notified by the Program Committee. This should not be the formal routine notice at all, but a special telephone call or letter, referring to the importance of his participation in the next meeting to discuss a specific case or subject. Other doctors interested in the subject raised or the types of treatment for such disease should be notified to come prepared to participate in the discussion. It should become a point of honour with each and every doctor to respond to such if it be at all possible to do so.

Many times discussion languishes because doctors hesitate to criticise the work of their colleagues, or to even suggest other treatment for fear it be construed as criticism. This attitude is fatal to the success of the meeting. It should be understood, particularly by the doctors in charge of cases, that the one and only object is to seek the truth and to concentrate all the experience and judgment of the entire staff upon the diagnosis and care of the patients in the Hospital. If there is disagreement with a diagnosis or treatment, such should be made in the meeting, not elsewhere, and such should be received without resentment. Such candour and frankness is possible, however, only on condition that no animosity be permitted to arise and, particularly, on the clear understanding that no further reference be made to the point after the adjournment of the meeting.

It is presumed of course that any possible disciplinary matters would be discussed in the appropriate committee and not by the Staff as a whole.

In addition to the discussion of interesting cases, with or without recovery, other features should be introduced to vary the meetings. Unusual pathological material or bacteriological cultures could be demonstrated; radiological displays are always of interest; new equipment or new methods can be demonstrated. Formal papers are usually best left to the meetings of the local Society, but frequently some member of the Staff could review the current literature on a certain subject, such as the newer treatments of cancer, post-operative care, etc. It is of particular importance to develop the keenest possible scientific spirit throughout the staff.

Staff Rules and Regulations - These would seem to need considerable revision. A Committee of the Staff should take this matter in hand and submit a revised code to the Executive Committee and to the Staffs. It is infinitely better that such be done by the Medical Staff itself rather than by the Board, but the revised Staff Rules and Regulations should be submitted to the Board for ratification.

While the effect of the decision referred to above would require consideration, all appointments should be on an annual basis. This is now done in nearly all larger hospitals. In case of action being required it is much easier to fail to reappoint than to dismiss.

Appointment of Interns:

So far the Calgary General Hospital has not had interns. For some time the Staff and Management doubted the desirability of such appointments, but the attitude now is distinctly favorable. As a matter of fact the Calgary General Hospital is now the only general hospital of its size in Canada which does not employ interns. The following statement from the recent report of the Standaridization Committee of the Hospital is strongly endorsed:

MEDICAL STAFF - cont'd.

"There is wide-spread opinion that a hospital the size and standing of the Calgary General Hospital cannot give the best service and efficiency without adequate interne services.

"It is suggested that the establishment of such services would mean increased attention to the patients in the matter of ordinary treatments and dressings; such a service would provide capable first or second assistants at major operations; internes would be available for help in the Case Room and at minor operations, large dressings and accident and fracture work; they would also carry out a large proportion of the more or less routine pathological work, thus releasing the skilled pathological staff for their special duties; they would assist materially in maintaining and keeping up to date hospital records, case histories, etc.; it would mean that medical services would be available in cases of emergency arising in or brought into the hospital until such time as a member of the staff could arrive to take charge of the case. Your Committee considers that the above summary is a fair statement of what internes might and should be expected to do. It is however pointed out that some organization of the Medical Staff in the establishment of services or departments would be necessary in order that the internes might receive a fair division of work and the instruction and supervision they would expect while filling these positions."

As interns are not easy to obtain, it would be highly desirable that the Hospital be placed upon the list of hospitals "approved" or the list of hospitals "recommended" for internship, by the Committee on Approval of the Canadian Medical Association. The Basis of Approval followed is somewhat strict and, as suggested in the above quotation, considerable organization of the medical staff and a creditable increase in the autopsy percentage would be necessary for listing as a properly accredited scientific institution.

Medical Records -

The medical records and the facilities for their acquisition were considered. While certain members of the Staff do make an effort to keep up their records and the Chairman of the Records Committee conscientiously endeavors to keep the records up to date, the majority of the records are poor and very incomplete. Very little appears on the chart while the patient is in hospital, most of the medical records being written up afterwards. A pre-operative diagnosis, however, is insisted upon.

The organization of this most essential Department is very haphazard. There is no record librarian, as found in most of the larger general hospitals. The clerical work is in the hands of two fairly busy members of the office staff; one is the switchboard operator and the other one of the clerks in the admission department. These girls do not see the charts until after the patient is discharged. The switchboard operator checks the medical records and endeavors to get the doctors to complete their charts. The records are then indexed and filed.

There is no stenographer assigned to the Operating room suite in the mornings as is now largely done. The doctors write their own notes as there is no available stenographer or librarian to whom dictation could be given.

The records are indexed as to:

1. Doctor in charge
2. Diseases
3. Operative record.

MEDICAL STAFF - (cont'd)

Complications are not cross-indexed, thus missing a very essential phase of the records. The writer was amazed to note that no system of naming diseases, or nomenclature, is used. This renders the records practically worthless for any purpose of compilation, or of general study. All indices are alphabetical. Thus a case of valvular leakage of the heart could be filed (and lost for further studies) under any one of the following alphabetical headings:

Heart - valvular disease
Endocarditis - chronic
Chronic Endocarditis - mitral
Mitral Regurgitation
Valvular Disease of the Heart
Valvular Leakage
Rheumatic Disease of the Heart, etc.

There are three or four well known nomenclatures available and one of these should be adopted and rigidly followed in all indexing and recording.

A standard monthly report is filled out and submitted to the Standardization Committee. The percentage of correct pre-operative diagnoses would not appear to be calculated. No post-natal form is in use - a serious omission.

The filing arrangements are very poor. Hospital records are now housed in three different buildings. More recent records are in a basement room without windows, the dusty and stifling atmosphere discouraging any reference to them.

Duties of the Case Record Committee - In fairness to the Case Record Committee, it would appear that the Committee is not getting as full co-operation from some of the Staff as would be desired. Moreover, while the committee is charged with the supervision of the records and is empowered to request their completion, the Committee is not given the right, when a record is unsatisfactory, to require its improvement. This situation should be corrected by the Medical Staff.

Monthly Letter - It is recommended also that a monthly letter should be prepared by the Medical Superintendent and sent to all members of the Medical Staff. This letter might contain comments on new equipment, services provided, special rates, and might clarify various points about the Hospital's regulations, etc. The Staff, or its Executive, and the Board might meet jointly for luncheon and a general discussion of mutual problems. There seems to be evidence of insufficient getting together.

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IV. GENERAL COMMENTS

An Out-Patient Department

Should one be established? During the past decade many such departments have been organized. They have long been popular in the East, but have not been developed so fully in the West, although in the last few years many hospitals have set up such services.

From the hospital viewpoint it is a liability, not an asset. It would be an asset only were there a special grant for such service, empty ward beds to be filled or medical school requirements to be considered. Sometimes such permits out-patient visits for treatment by those who might otherwise occupy beds. Whether or not it is needed for the patients depends upon how adequately their needs are now met by the present arrangements for medical care.

In the final analysis, the decision usually rests with the Medical Staff. Unless the doctors desire such and are willing to volunteer faithful daily service, the Department would prove a failure. It would appear that the Medical Staff has given some thought to this matter and "while many advantages can be seen resulting from such a move, your Committee feels that it is unwise to consider this possibility at the present time." This should determine the present policy.

Flat Rates:

Flat, all inclusive, rates might be developed for various services, as, for example, the obstetrical service, the pathological laboratory etc. The former particularly stimulates private patronage. The present flat laboratory fee is for city patients only.

Women's Auxiliary and Junior Aids:

Women's Auxiliaries have proven to be such a valuable means, not only of arousing enthusiastic public wympathy, but of making most acceptable financial support, that such should be organized at the Hospital without delay.

The younger women, working through their own organization, can take charge of accessories for the nursery, the paediatric department, etc. and can be of inestimable assistance. The wives of members of the Medical Staff and the Board and Hospital friends should take the lead.

Control of Admissions:

There seems to be a general impression (so often associated with civic hospitals) that, because the City owns the Hospital, any and all types of patients can be admitted and retained there. If there is inadequate control or lack of firmness such should be corrected. If there is insufficient power conferred upon the Medical Superintendent such should be given.

Lack of Social Service:

The lack of social service organization in Calgary lessens considerably the service which the Hospital can offer to the poorer citizens. Moreover, such lack makes it harder for the Hospital to check up on many of the non-pay patients.

Visitors are hard to control. Hours are 2 - 4 and 7 - 8 daily. The evening hours might readily be reduced to certain evenings only, for such does delay the nursing considerably. The number of visitors per patient is not controlled. This should be done.

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V. ISOLATION HOSPITAL

The Isolation Hospital has a capacity of 75 beds located in two buildings. These buildings are quite old and in many places the foundations, of comparatively soft stone, are crumbling. The buildings are not well laid out for multiple diseases. The westerly building, with twenty-seven beds, is only used when the census is high. There is practically no signal system.

The regular staff is as follows:

Matron - superintendent
Night - superintendent
Day supervisor
Cook
Porter
Maid

One of the nurses is normally on a part-time basis. Pupil nurses from the General Hospital are assigned as the work warrants.

The above staff is sufficient when the census is low. Last year, for instance, the average occupancy was 14 patients. At the present time when it is filled to capacity (73 on day of study) the staff is an augmented one:

6 Graduate nurses
6 Pupil nurses (C.G.H.)
2 Cooks
2 Maids
1 Porter

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The medical work is directed by the Medical Health Officer. However, there is a visiting Medical Staff as in the case of the General Hospital. There is a small operating room for emergency work.

There is no charge to city patients.

Supplies are requisitioned from the Calgary General Hospital stores, and brought over on a truck.

COMMENTS

Unfortunately it will be necessary to make provision for isolation cases for some time to come. While the present buildings are not satisfactory, the other needs at the General Hospital are so much greater, that any major expenditure should be there rather than at the Isolation Hospital.

Over a period of years the calls upon the Isolation Hospital have been gradually decreasing, but epidemics like the present one of scarlet fever indicate that ample provision should be available. While last year the many unused beds would have led one to suggest tearing down the westerly building, there is at the present time a waiting list for admission. This possibility must be kept in mind in subsequent plans.

Finance - In the minutes of the Hospital Board Meeting of May 28th, 1936, it was noted that the estimates for the Isolation Hospital were being considerably over-expended. As additional pupil nurses could not be spared from the General Hospital, graduate nurses were being added temporarily to the staff of the Isolation Hospital, in addition to other personnel.

ISOLATION HOSPITAL - (cont'd)

As the demands upon an isolation unit are very irregular, it would seem impossible to make any accurate estimate of expenditures. Provided the Hospital is economically operated and all appointments other than the skeleton permanent staff are but temporary for peak periods, there is nothing to do but accept the necessity for these supplementary estimates or reports. Because of the 1936 epidemic of scarlet fever, the current expenses will be well above the average.

Nursing - Owing to inadequate plumbing and segregation facilities, an extra responsibility for observance of technique is thrown upon the nursing staff. This added responsibility would appear to be appreciated and met by the nurses.

Pupil nurses return to the residences at the General Hospital and mingle with other nurses. While the day is gone when it was considered necessary to lock up any person having contact with communicable diseases, nevertheless greater precautions might be taken against possible transportation of the infections. All regulations concerning the conduct of the pupil nurses at the Isolation Hospital, on and off duty, should be carefully revised. Particularly should there be precautions against the mingling of nurses handling scarlet fever and erysipelas and those on the obstetrical service.

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